Testimony by John P. Burke, F.S.A., M.A.A.A.
Representing BCBSM Before the Michigan House Insurance Committee
on House Bills 5282 and 5283 (as of 10/10/2007)
Hearing on October 17, 2007

1. Identification and Qualifications

My name is Jack Burke. I am a Principal with Milliman, Inc., an independent national firm of consultants and actuaries, with my office located in the suburban Philadelphia area.

I have been a consulting actuary with Milliman for the past 8 years, specializing in health insurance. During the 16 years prior to joining Milliman, I held a number of actuarial and management positions at United Healthcare and at Aetna. I am a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries.

I am appearing here at the request of Blue Cross and Blue Shield of Michigan (BCBSM). The professional actuarial views I will be providing, while having been broadly peer reviewed within Milliman, are my own and not those of either Milliman or BCBSM.

2. Scope of Testimony and Overview

Our firm provided input to BCBSM as the company developed its position on health care reform for the health insurance market for individuals not eligible for Medicare. As part of that support, we developed for BCBSM an outline of "Actuarial Principles and Considerations," based on its articulation of the "Goals and Required Elements" for such reform. They are attached as part of my testimony. Subsequently, various Milliman health consultants and I have also reviewed the provisions of Chapter 37A of House Bill 5282, as of 10/10/2007, pertaining to such reform, and its companion House Bill 5283. These form the foundation for my comments regarding House Bills 5282 and 5283 as

they pertain to individuals not eligible for Medicare. My understanding is that House Bill 5283 is a companion bill which makes BCBSM subject to the provisions of Chapter 37A. My review was as an actuary, in the context of the actuarial principles and considerations we had previously developed. If the goals and required elements change, the application of the actuarial principles may change to some extent.

I would like to highlight for you very briefly what I believe to be the most important observations regarding individual health insurance reform in Michigan, and for Chapter 37A as it relates to such observations. I would also like to distinguish between what is being proposed for the Michigan individual insurance market, and what has been tried unsuccessfully in certain other States. In that regard, accompanying this testimony is a chart which highlights a comparison of key provisions between the proposed reform for Michigan and selected States that previously enacted comprehensive reform in the individual health insurance market.

3. Addressing Access, Participation, and Rating

At the heart of virtually all of the "Goals of Individual Health Insurance Reform" articulated by BCBSM, and most of its related "Required Elements of Reform," are matters involving access, participation, and rating. These issues are central to the viability and sustainability of the individual health insurance market, and they play a critical role in meeting social policy objectives associated with making coverage available on a widespread basis to eligible individuals in Michigan.

Addressing these issues now is particularly important for Michigan. As a State, you can expect to face a growing need for sound and fairly priced individual products in your local markets. Today, however, you have a great deal of inconsistency in the regulation and, as a consequence, the operation of the various types of carriers in the market. This has created artificial barriers to effective competition in the individual market and produced unsound financial consequences to some participants. It does not serve well either consumers or, ultimately, the insurance industry as a whole.

Chapter 37A addresses these issues in a way that is intended to encourage fair market competition and to avoid pitfalls revealed by the unsuccessful reform efforts in certain other States. It would allow carriers to decline to offer coverage to individuals whose health at the time of application is determined to be uninsurable, while providing an identified source of coverage for such high risk individuals through BCBSM; and it provides an explicit means for helping to fund excessive overall costs for the pool of such individuals. Chapter 37A also encourages individuals to seek and maintain health insurance coverage, by permitting the exclusion of diagnosed pre-existing conditions for a period of time for applicants who had not maintained continuous coverage.

Chapter 37A recognizes that reasonable alignment of rates with the expected costs for an individual is an important actuarial principle. It addresses this issue in a way that is intended to balance such alignment with limitations on the resulting overall amount of variation in rates among individuals. For example, it allows carriers to recognize differences in expected costs for different individuals due to health conditions at the time of application, but within limits. This is intended to help achieve balance between the competitiveness of rates for individuals with favorable risk characteristics, and some constraint on the amount of variability between rates for such individuals and for those with unfavorable risk characteristics. By doing so, one of the chief contributors to market disruption in other reform States is addressed.

A complex issue to address is the extent to which changes in an individual's risk characteristics – age, health conditions, etc. – can be recognized in rates. Such changes in risk characteristics are directly related to changes in expected costs. My understanding of Chapter 37A is that it addresses this matter by prohibiting the reclassification of a specific individual for rating purposes based on changes in the health condition of that individual and limits increases to 10% annually for the combined impact of (a) aging by that individual, and (b) changes associated with managing the ten rating tiers within the 2:1 constraint. While significantly limited, this increase is intended, as well, to recognize mistakes made in certain other States and to avoid their adverse consequences in Michigan, while providing protection for insured individuals.

Indeed, the current law, as it has been applied to Blue Cross, is closer to these other states' unsuccessful attempts at reform, which would explain the results being seen in this market in Michigan.

4. Overall Conclusions

Chapter 37A, as presented in House Bill 5282 and made applicable to BCBSM by 5283, represents a reasonable and balanced approach to addressing the "Actuarial Principles and Considerations" that apply to individual health insurance market reform in Michigan, based on the "Goals and Required Elements" stated for such reform. I believe that the core provisions are sound based on these principles and would contribute to an effectively functioning market.

As the bill moves forward, various parties may wish to debate details, and certain clarifications to the drafting may be useful to help ensure consistent interpretation for implementation. For example, in defining actual loss ratio, all reasonable costs such as unpaid claims, policy reserves, and non-claim medical costs funded by the company (including health center costs) should be recognized. My conclusions also assume that implementing regulation details reflect a reasonable interpretation. If the core provisions of the bill change materially, my conclusions may change as well. Over time, as experience is gained, all affected parties will want to monitor the law's effectiveness, and adjust accordingly.

A number of other States have created significant market disruption due to what were surely well intended, but poorly conceived reforms. House Bills 5282 and 5283 represent, in my judgment as an experienced health care actuary, a reasonable attempt to improve the functioning of the individual health insurance market in Michigan, approached in a way which provides reasonable protections to individual insureds, but which avoids or mitigates the mistakes of previous unsuccessful reforms in other places.

Thank you. I would be happy to entertain any questions.

Foundation for Individual Health Insurance Market Reform in Michigan[1]

A. Goals of Individual Health Insurance Market Reform[2]

1. **Broad Access** – Access to market-based comprehensive Individual health insurance coverage for all permanent, legal residents of the State not eligible for an employer or government-sponsored plan.

2. **Broad Participation** – A structure that encourages participation of young and healthy eligibles who may fully expect low or no claims, and truly only need insurance against unforeseen claims.

3. **Continuous Participation** – Availability of coverage and incentives for eligible Individuals to maintain continuous coverage without fear of its involuntary termination or of excessive rate increases due to a change in the Individual's duration of coverage, age, or health status.

4. **High Risk Applicants** – Access to market-based coverage by high risk eligible Individuals as well as by all others, in a way which reduces overt adverse selection by such Individuals and which then broadly spreads the excess costs of coverage for them. To the extent the excess cost is allocated to a particular market segment (e.g., insured products), all carriers in that market (and thus their customers) should fairly share in the allocated costs.

5. **Value-Based Rate Structure** – Realistic reflection in rates of the value received by a covered Individual, consistent with expected costs; and reasonable proportion of premium returned as benefits.

6. **Rate Stability** – Rating requirements and practices which support a reasonable progression of rates and rate stability over time.

7. **Financial Viability of Carriers** – Statutory provisions and regulatory approval processes which provide all carriers with reasonable operating flexibility and with an opportunity to achieve a fair and reasonable financial return.

B. Required Elements of Reform[2]

1. **Guaranteed Availability** – All eligible Individuals must be able to purchase comprehensive coverage, through either mandatory guaranteed issue by all carriers or some alternative carrier-supported mechanism that provides a safety net for high risk Individuals. All actively marketed Individual products or benefit plans must be available to eligible applicants, without permanent exclusions due to an Individual's health conditions or impairments.

   To avoid selective shifting of high cost enrollees by employer and government sponsored groups, the definition of "eligible" must be carefully constructed so as to exclude Individuals that have access to such plans.

2. **Pre-Existing Medical Conditions** – Coverage of pre-existing conditions may be excluded for a reasonable period of time. This limiting provision would not apply to an Individual losing eligibility for coverage under an employer or government-sponsored plan (including exhaustion of COBRA eligibility) if application for Individual coverage occurs within a reasonably short period of time. Also, pre-existing conditions must be robust enough to encourage participation before the emergence of a condition or medical need.

3. **Rate Structures** – Rate differences among products or benefit plans must reflect the actuarial value of the benefits provided (without regard to the risk characteristics or experience of the Individuals enrolled under the different benefit plans involved), as well as reasonable recognition of the cost of dependent coverage (spouse, children). Reasonable discounts may be provided for maintaining healthy lifestyles or participating in programs designed to promote and encourage healthy lifestyles.

   Rates may recognize the reasonable expected impact of the risk characteristics of a covered Individual within acceptable categories of risk characteristics, so long as such recognition in rates is consistently applied to all Individuals. Rates may also reflect other morbidity-related risk characteristics on a discretionary basis, within an acceptable maximum range and subject to reasonable limits on year-to-year changes in rates due to any such morbidity-related considerations.

Foundation for Individual Health Insurance Market Reform in Michigan[1]

B. Required Elements of Reform[2] (cont'd)

4. **Guaranteed Renewability** – Individuals enrolled under a product or benefit plan must be offered the opportunity to continue coverage under the plan, until such time as it is closed by the carrier and cancelled for all enrolled Individuals. At such time, the Individuals involved must be offered the opportunity to transfer to any alternative plan actively marketed by the carrier that has an actuarial value equal to or less than the terminated plan. The rates for the transferring Individual would be subject to the same provisions and limitations that would apply if the Individual's plan had renewed instead of being cancelled (with regard to actuarial values and changes in morbidity-related risk characteristics).

5. **Compliance by Carriers** – Rates must be filed with the State's Insurance Department, but would be subject to "file and use" procedures. Every filing must be accompanied by an actuarial certification as to the adequacy and reasonableness of the rates and the compliance of the rates with the State requirements, including meeting a reasonable minimum loss ratio standard. An annual actuarial certification of carrier compliance with the State Individual product requirements must be submitted.

1 This chart is an attachment to the testimony by John P. Burke, F.S.A., M.A.A.A., representing BCBSM before the Michigan House Insurance Committee on House Bills 5282 and 5283 (as of 10/10/2007) at its hearing on October 17, 2007.

2 Policy statement, provided by BCBSM.

Actuarial Principles and Considerations that Apply*

In order for an Individual health insurance market to operate effectively and be sustainable, while attempting to meet the stated goals and requirements for reform (see "Foundation for Individual Health Insurance Market Reform in Michigan"), adherence to certain important actuarial principles and considerations is essential. These principles are inter-related and require balance among them. Specific principles include the points below.

1. **Alignment of Rates and Expected Costs** – Carriers must be able to structure rates so as to reasonably align the rates offered to an Individual with corresponding expected costs. This includes the ability to recognize in the rating structure:

   - ***The actuarial value of differences among products and benefit plans***, with rate levels varying accordingly. The most widely recognized and important of these for the Individual health insurance market are benefit provisions (including the impact of benefit richness on utilization), provider network characteristics and reimbursement levels, and clinical management of care.

   - ***Differences in expected costs within acceptable categories of risk characteristics***, with rate levels varying according to the actuarial values of such characteristics. The most widely recognized and important of these for the Individual health insurance market are age/gender, family coverage (e.g., spouse, child), and geographic area.

     The actuarial values for age-sex factors associated with comprehensive health insurance coverages might typically fall between 0.40 and 3.00, for an overall range of approximately 7:1 for single contracts (somewhat less dispersion for family contracts). Geographic factors should reflect health care cost differences among distinct service areas for receiving health care services. Under a sound rating system, such risk characteristic rating factors would be actuarially determined and applied consistently to all enrollees.

- ***Differences in expected costs due to health status, duration, and/or other morbidity-related factors***, within limits that balance broad participation, the range of premium rates, and the cost of external subsidies necessary to support the system. The magnitude of expected cost differences due to morbidity-related factors may be (and frequently is) uncertain, thereby requiring the application of informed professional judgment; reasonable discretion is desirable and necessary. New business morbidity adjustment factors (beyond age-sex category factors) typically used by different carriers vary widely.

  The width of this band can never be so great as to include every Individual from the perfectly healthy to end-of-life support. The width must balance the competing objectives of encouraging broad participation, maintaining financial viability, and supporting the overall stability of Individual rates. Having no limit on the incorporation of health status adjustments to rates may be sustainable over time, but will not produce stable rates. On the other hand, allowing no recognition of health status in rates is inefficient and unsustainable.

  It would not be unusual to find new business morbidity factors which vary within an overall range of 2:1 to 3:1 or wider (with Individual applications which are judged to be more adverse then either declined for coverage, or managed as high risk individuals).

  For Individual applicants judged to be more adverse in health status than provided for by the level of variation reflected in the range of rates available, the Individual applicant should reasonably be considered "uninsurable" under the rate structure. Such applicants need to be addressed separately as high risk Individuals.

2. **High Risk Individual Applicants** – Special consideration and treatment is required for high risk Individual applicants (as indicated above), if they are to be included within the scope of the Individual insurance market. To the extent that the maximum variation in rates for differences in enrollee health status should be limited (e.g., to 2:1 or 3:1), Individual applicants who are judged by a carrier to be more adverse in health status than its rate structure is designed to accommodate can be characterized as "uninsurable" under the rate structure. This means that they are expected to have costs in excess of the highest rate level offered. Implications include:

Actuarial Principles and Considerations that Apply* (cont'd)

- In general, a relatively ***wide range of variation in rates*** permitted and used to recognize health status and other morbidity-related factors should produce a greater proportion of Individual applications which a carrier can appropriately accept. Likewise, it should produce a smaller proportion which would need to be classified as "uninsurable" under the carrier's rate structure, and therefore require treatment as a high risk Individual.

- If a carrier were simply required to accept "uninsurable" applicants (as defined above) on a ***guaranteed issue basis***, with no other financial provision, then implicitly the carrier is expected to subsidize all such applicants who enroll through higher rates charged to all other Individual enrollees. This financial burden may be unevenly spread among carriers, and could cause a particular carrier's rates to spiral upward over time.

- If, alternatively, all "uninsured" applicants (as defined above) were considered as a special class, whose excess costs were to be spread broadly among carriers in an equitable fashion, then an adequate and reliable ***assessment provision*** of some form to subsidize such excess costs would be required. Among possible alternatives would be an assessment or tax on all carriers, or a surcharge on provider services to all members with group or nongroup health care coverage, or a provider tax. The broader the assessment, the less likely it is to lead to damaging consequences in a voluntary market.

- In the alternative situation described above, with an adequate and reliable source of subsidy available, possible alternatives for the ***mechanism to provide coverage*** might be:

  - a centrally administered ***high risk pool***, with the assessed subsidy funds used to defer the excess costs for the high risk Individuals;

  - mutualization or some other form of ***pooling arrangement among carriers***, so that the excess costs for identified high risk Individuals can be spread proportionately among all carriers; or

- the administration of such coverage through one or more ***contracting high risk Individual coverage carriers***, with the appropriate subsidy funds to cover the excess costs for the high risk Individuals allocated among the contracting carriers in an equitable fashion.

A satisfactory market-wide solution to the coverage of high risk Individuals is necessary to meet the goals and required elements identified for Individual health insurance market reform.

3. **Deterring Adverse Selection** – Eligible Individuals must be prevented from selecting against carriers to the extent possible. Carriers will need to have meaningful, significant waiting periods for eligibility and pre-existing condition limitations upon initial enrollment. In addition, they will need to be able to consider requests for coverage upgrades in the same manner as new applications (in terms of initial rate determination and pre-existing condition limitations).

4. **Changes in Risk Characteristics** – Changes in categorical risk characteristics (e.g., age or geographic area) can be addressed consistently among Individuals and predictably over time through the application of actuarial pricing factors in determining Individual rates. Changes in morbidity-related risk characteristics (e.g., health status), however, involve both durational tendencies and underwriting judgment on a case-by-case basis. This latter aspect may have limited predictability over a long period of time. Reasonable discretion in recognizing the effect of changes in morbidity-related risk characteristics such as health status on rate requirements for an Individual can be expected to lead to a closer alignment of rates with expected costs, and thereby to contribute to the continued viability of the Individual health insurance market.

   The durational element of such changes, however, can be accommodated through the use of active life policy reserves. This technique involves pricing on a basis that recognizes the durational tendency of "select" new members with favorable health status to have costs that move over time toward "ultimate" levels. Such a pricing technique may reduce the extent to which case-by-case recognition of changes in an Individual's health status is necessary in rating, thereby contributing to rate stability.

5. **Minimum Loss Ratios Determination** – Requirements as to the return of premium in the form of benefits are typically expressed as minimum loss ratios. In establishing and measuring compliance with minimum loss ratios, it is important that key elements be adequately recognized and properly accommodated. These include:

   - Establishing minimum loss ratio requirements which enable recovery of administrative expenses, commissions, and other operating costs – as well as a reasonable level of margin and profit.

   - Defining benefit costs to include not only payments to health care providers for services rendered to members, but also such items as carrier operating costs directly attributable to health care provider contracting, management of care costs, and network access fees.

   - Recognizing either duration of member enrollment or actuarially-based active life policy reserves in the establishment and determination of compliance with minimum loss ratio requirements.

   Regarding active life policy reserves, as indicated above, such reserves may help some carriers to better achieve rate stability for covered Individuals over time, and to more readily comply with limitations on rate changes for an enrolled Individual year-to-year due to changes in his/her health status, duration, and/or other morbidity-related risk characteristics.

6. **Actuarial Certifications** – Prescribed loss ratio testing and certifications by a qualified actuary can be effective means of helping to achieve compliance.

7. **Individual Means and Affordability** – Even with guaranteed access and reasonable rating structure constraints, some eligible Individuals will choose not to purchase coverage for any of a variety of reasons, and other eligible Individuals realistically may not have the means to afford coverage – even though it is available on a reasonably priced basis. This is a matter of personal choice, income, and financial resources coupled with the underlying cost of health care services – not due to insurance pricing. Any effective remediation of this type of situation requires outside sources of funding, and cannot be solved by artificial constraints on rates or rating mechanisms without risking severe damage to the operation of the market.

   It should be duly noted that mandated benefits or service coverages nearly always serve to increase expected costs, and therefore increase premium rates.

Actuarial Principles and Considerations that Apply* (cont'd)

Eliminating expensive mandates is one way to reduce costs and thereby improve the affordability of health insurance premiums for Individuals.

* This chart is an attachment to the testimony by John P. Burke, F.S.A., M.A.A.A., representing BCBSM before the Michigan House Insurance Committee on House Bills 5282 and 5283 (as of 10/10/2007) at its hearing on October 17, 2007.

Individual (Under 65) Market Reform

Highlights of Comparison of Michigan House Bill 5282 (Chapter 37A) to Selected States*

Reform Provisions	Michigan Proposal	Kentucky	Maine	Massachusetts	New Hampshire	New Jersey	New York	Vermont	Washington
Guaranteed Access to Coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Acceptance Provisions									
Guaranteed Issue:									
Mandated for All Carriers	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
High Risk Pooling	Yes	No	No	No	No	Alternative	Alternative	No	No
Pre-Existing Conditions Exclusion	Permitted	Limited	Permitted	No	Limited	Permitted	Permitted	Permitted	Minimal
Rating Provisions									
Member Characteristics Allowed:									
Age	Realistic	Limited	Minimal	Minimal	Limited	No	No	Minimal	Limited
Geographic Area	Permitted	Limited	Minimal	Moderate	No	No	Permitted	Minimal	Permitted
Health Status of Individual:									
Initial Conditions	Moderate	No	No	No	No	No	No	No	No
Subsequent Changes	No	No	No	No	No	No	No	No	No
Tier Management	Modest	No	No	No	No	No	No	Minimal	Limited
Smoking Status	Permitted	No	Permitted	No	No	No	No	No	No
Range Limits on Rating Factors	Moderate	Narrow	Very Narrow	Very Narrow	Narrow	No Variation	No Variation	Very Narrow	Narrow

*This chart is an attachment to the testimony by John P. Burke, F.S.A., M.A.A.A., representing BCBSM before the Michigan House Insurance Committee on House Bills 5282 and 5283 (as of 10/10/2007) at its hearing on October 17, 2007. It is intended to compare the key elements of the proposed Michigan House Bill 5282 (Chapter 37A) to certain other states that have previously enacted comprehensive reform provisions. Many of these states have seen material revisions to their initial law, including some that have been partially or substantially repealed in reaction to market disruption. This chart reflects the law before such repeals. However, in some states, the very first law was quickly modified (within a year or so), in which case this chart reflects the law after such initial modification. The primary source for this information is the August 2007 AHIP report on The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets, located at http://www.ahip.org/content/default.aspx?docid=20736

State-specific Notes

Michigan Proposal: A 2:1 tier band would apply to health status, and a 9:1 rate band would apply to age and health status combined.
Kentucky: A 3:1 rate band applied to age. Much of the law has since been repealed.
Maine: A 1.5:1.0 rate band applied to age, occupation, and geographic area combined.
Massachusetts: A 2:1 rate band applied to age, and a 1.5:1.0 band applied to geographic area.
New Hampshire: A 3:1 rate band applied to age. 25% rate increase cap, excluding trend and changes in age category and family composition. Much of the law has since been repealed.
New Jersey: An assessment and loss pooling mechanism applied.
New York: Risk adjusting pooling arrangement applied across all carriers for demographics and for certain catastrophic medical conditions.
Vermont: 1.5:1.0 rate band applied to all rating factors combined for commercial carriers, but BCBSVT and HMOs required to use pure community rating. 20% rate increase cap.
Washington: Limits applied on age and duration rating adjustments. Much of the law has since been repealed.